

41167

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

4984

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH

(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution: 620 Forest 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 54 yr. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson 48
(c) City or town K.C. (If outside city or town limits, write "RURAL")
(d) Street No. 620 Forest (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Italy

3. (a) PRINT FULL NAME Giuseppe Matacia

3. (b) If veteran, name war WW 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Jan - 27 1868
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 27 If less than one day hr. min.

9. Birthplace Italy 5
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name Giuseppe Matacia
13. Birthplace Italy 5
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Smeraldo

(b) Address 620 Forest

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/43
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's

18. (a) Signature of funeral director Schubert

(b) Address 901 E. 5th

19. (a) 11-26-43 (Date received local registrar) (b) T. C. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24
year 1943 hour 5:30 minute P.M.

21. I hereby certify that I attended the deceased from Nov. 1942
to Nov. 24 1943
that I last saw him alive on Nov. 24
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration
Due to Senility
Due to 93
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature A. E. Scardina (M. D. or other) 2 D. O.
Address 2603 Indep. Ave Date signed 11/26/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S. No. 2
M-2-43
5-17-39
I X35897

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Ray E Snow*

Licensed Embalmer No..... *2560*

P. O. Address..... *16 E. 7th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.